Michigan Consumers for Healthcare

Keeping Health Insurance Premiums Affordable

Meaningful Rate Review Provides Real Benefits for Michigan Consumers

Strong rate review mechanisms help keep insurance premiums more affordable for consumers. While the Affordable Care Act includes some rate review mechanisms, the majority of this crucial regulatory power still rests with the states. Blue Cross Blue Shield of Michigan's (BCBSM) conversion bills, as currently drafted, would undermine Michigan's ability to protect consumers from runaway rate increases.

Across the nation, the trend is toward stronger, more consumer-friendly rate review structures. Recently, states like Oregon, New York, and Colorado *have strengthened, yet streamlined* their rate review processes. The result? Improved consumer engagement; lower rate increases; and more certainty and quicker rate approvals for insurers.

Michigan's Current Rate Review System

Because more than 71 percent of Michigan consumers with health insurance are covered by BCBSM, its rate increases effectively set the bar for all insurers in the state. Consequently, all Michigan consumers are, in some way, protected by the current rate review provisions in Public Act 350, including:

- Specific requirements for the filing of rate increase documents, which the insurance commissioner must deem complete;
- Notice of a rate increase request provided to those (including consumers) who request it;
- Right to a hearing on the rate increase request, if requested by a policyholder, the attorney general, the insurance commissioner, or BCBSM;
- A defined standard of review for rate increase requests: premiums must be equitable, adequate and not excessive;
- A burden of proof that rests on BCBSM; and
- Medigap rate oversight that protects seniors and people with disabilities.

If current Blue Cross Blue Shield bills pass, consumers would instead be left with:

- No consideration of an insurer's surplus and profit, or rate affordability, when an rate increase is submitted;
- A 30-day deemer: if the commissioner does nothing, rates are automatically approved;
- No clear standard of review: currently, the commissioner "may" disapprove the form submitted for a rate increase, but there is no requirement that the form meet minimum standards;
- Out-of-date MLR standards: Michigan's Medical Loss Ratio standards have not been updated to comply with the Affordable Care Act;
- Hearings only upon the request of an insurer; and

- Silence as to burden of proof.

The Better Way: Streamlined, Uniform, and Robust Rate Review for All Insurers

Michigan should follow the course of other states, like Oregon, New York, and Colorado, which are protecting consumers from unsustainable health insurance rate increases, while providing uniformity, certainty, and quick decisions on rate requests. These protections benefit both insurers and consumers, and include:

- A streamlined and equally applied 45-day maximum wait for a decision;
- The preservation of most current Michigan consumer protections, such as notice of rate increase requests; a defined standard of review; a consumer's right to a hearing; and the burden of proof resting with the insurer; and
- Clear and consistent requirements *that apply to all insurers*, bringing more certainty and efficiency to Michigan's market, while keeping rates more affordable for consumers.

COMMITTEE AMENDMENT NO. ____

Sec. 2242. (1) Except as otherwise provided in Section 2236(8)(d), a group disability policy shall not be issued or delivered in this state unless a copy of the form has been filed with the commissioner and approved by him or her.

(2) When an insurer files a schedule or table of premium rates for individual or small group health insurance, the Commissioner shall open a 30-day public comment period on the rate filing that begins on the date the insurer files the schedule or table of premium rates. The Commissioner shall post all comments to the Office of Financial Insurance Regulation website without delay. The Commissioner shall hold a public hearing on the proposed rate change during the 30 day public comment period, and give notice of the public hearing subject to MCL 15.261.

(3) Subject to Subsections (4)-(6) the commissioner shall give written notice to an insurer approving or disapproving a rate filing, or with the written consent of the insurer, modifying a rate filing submitted under Subsection (2) no later than 10 business days after the close of the public comment period. The commissioner, after conducting an actuarial review of the rate filing, may approve a proposed premium for a health benefit plan for small employers or for an individual health benefit plan if the commissioner's discretion the proposed rates are:

a) Reasonable and not excessive, inadequate or unfairly discriminatory; and

b) Based upon reasonable administrative expenses.

(4) In order to determine whether the proposed premium rates for a health benefit plan for small employers or an individual health plan are reasonable and not excessive,

inadequate or unfairly discriminatory, the commissioner shall consider:

a) The insurer's financial position, including but not limited to profitability, surplus, reserves, and investment savings;

b) Historical and projected administrative costs and medical and hospital expenses;

c) Historical and projected loss ratio between the amounts spent on medical services and earned premiums;

d) Any anticipated change in the number of enrollees if the proposed premium rate is approved;

e) Changes to covered benefits or health benefit plan design;

f) Changes in the insurer's health care cost containment and quality improvement efforts since the insurer's last rate filing for the same category of health benefit plan;

g) Whether the proposed change in the premium rate is necessary to maintain the insurer's solvency or to maintain rate stability and prevent excessive rate increases in the future; and

h) Any public comments received.

(5) A rate is not excessive if the rate is not unreasonably high relative to the following elements, individually or collectively:

a) provision for anticipated benefit costs;

b) provision for administrative expense;

c) provision for cost transfers, if any; and

d) provision for a contribution to or from surplus.

(6) A determination as to whether a rate is excessive shall be made relative to the following elements, individually or collectively:

a) reasonable evaluations of recent claim experience;

b) projected trends in claim costs;

c) the allocation of administrative expense budgets; and

d) the present and anticipated unimpaired surplus of the health care corporation.

(7) To the extent that any of the elements in Subsection (6) (a-d) are considered excessive, the provision in the rates for these elements shall be modified accordingly.

(8) The administrative expense budget must be reasonable, as defined by federal law.

(9) A rate is equitable if the rate can be compared to any other rate offered by the health care corporation to its subscribers, and the observed rate differences can be supported by differences in anticipated benefit costs, administrative expense cost, differences in risk, or any identified cost transfer provisions.

(10) A rate is adequate if the rate is not unreasonably low relative to the elements prescribed in subsection (1), individually or collectively, based on reasonable evaluations of recent claim experience, projected trends in

claim costs, the allocation of administrative expense budgets, and the present and anticipated unimpaired surplus of the health care corporation.

(11) Except for identified cost transfers, each line of business, over time, shall be self-sustaining. However, there may be cost transfers for the benefit of senior citizens and group conversion subscribers. Cost transfers for the benefit of senior citizens, in the aggregate, annually shall not exceed 1% of the earned subscription income of the health care corporation as reported in the most recent annual statement of the corporation. Group conversion subscribers are those who have maintained coverage with the health care corporation on an individual basis after leaving a subscriber group.